STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
THIE TEAM	or condition	155810	B. WING		00	04/01/2016	
				CTD FFT A	ADDRESS CITY STATE TIP CODE	0 1/0 1/	20.0
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE VERNON ST		
VERNON	VERNON MANOR CHILDRENS HOME				6H, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	Complaint IN00 Complaint IN00 Federal/State de allegations are consumption of the second of the se	196359 - Substantiated. ficiencies related to the fitted at F157 and F224. March 29, 30 and 31, 2016 : 000274 r: 155810 00271660	F 00	000	This plan of correction constitution my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law. Plan of Compliance is effective: Apr 18, 2016 Vernon Manor requestinged in the 2567 for the sur completed April 1, 2016: we request a reduction in the scoland severity of finding F157 at the removal of finding F224 Mistreatment, Neglected Misappropriation. All findings associated with these tags related to the same individual, Reside B.	of fillssts vey pe nd	
F 0157	483.10(b)(11)						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 04/01/2016			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
SS=J Bldg. 00	NOTIFY OF CHAN (INJURY/DECLIN) A facility must immoresident; consult we physician; and if kelegal representation member when the the resident which the potential for resident's physical status (i.e., a deteor psychosocial status (i.e., a deteor p	NGES E/ROOM, ETC) nediately inform the with the resident's nown, notify the resident's re or an interested family re is an accident involving results in injury and has quiring physician inficant change in the land, or psychosocial rioration in health, mental, atus in either life ions or clinical need to alter treatment a need to discontinue an eatment due to adverse to commence a new form decision to transfer or dent from the facility as 12(a). Ilso promptly notify the pown, the resident's legal interested family member range in room or ment as specified in a change in resident rights State law or regulations as raph (b)(1) of this section.	F 0157	F157J Physician Notification Corrective action for affected residents: Resident B discharged Identification of others at risk: Review of nurs	04/18/2016		
	(Resident B).			progress notes for changes of condition and physician			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5PYK11

Facility ID: 000274

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		155810	B. WING 04/01/2016			6	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VERNON ST		
VERNON	N MANOR CHILDRE	ENS HOME			SH, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	MPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE
	The immediate jeopardy began on				notification for the past two we reveal no areas of concerns.	eks	
		e facility failed to notify			Measures to ensure this def	icit	
		an elevated temperature			practice does not recur: The		
	of 103.9 degrees	s Fahrenheit (F). The			nursing staff were re-educated	d on	
	Executive Direc	tor, Director of Nursing			regulation F157 regarding		
	and Regional Di	rector were notified of			change of condition including)	
	the immediate je	eopardy on 3/31/16 at			notification of physician; and		
	12:00 p.m. The Immediate Jeopardy was				policy & procedures regarding notifications. Monitoring of		
	removed 4/1/16 when the facility				corrective action: Residents		
	developed and implemented a systematic				with significant changes in		
	plan of correction.				condition will be audited 5 time	es	
	pian of correction.				weekly for 6 months, then 2 til		
	F: 1:				weekly for 6 months. Results		
	Findings include) :			this monitoring will be reported		
					through the QA Committee for further		
	_	eview on 3/29/16 at 9:55			recommendations. Vernon		
	a.m., the clinical	record indicated			Manor requests changes in tw	o l	
	Resident B was	admitted to the facility			deficiencies alleged in the 256		
	on 10/27/12. Di	agnoses included, but			for the survey completed April		
	were not limited	to, spastic quadriplegic			2016: we request a reduction		
	cerebral palsy, p	profound intellectual			the scope and severity of finding F157 and the removal of finding		
	disability, anxiet				F224 Mistreatment, Neglected	•	
	_	asterostomy tube. The			Misappropriation. All findings		
		Set (MDS) quarterly			associated with these tags rel	ate	
		d 1/7/16, indicated			to the same individual, Reside	nt	
		unable to complete the			B. Please see attached IDR		
		•			request		
		Mental Status (BIMS).			Resident B was admitted		
		severely cognitively			Vernon Manor on		
	impaired.				10/27/2012. His diagnose	es	
					included spastic		
	During review o	f a progress note dated			quadriplegic cerebral pal	sy,	
	3/13/16 at 6:45 p	o.m., RN #1 noted a			profound intellectual		
	fever. The note	indicated the nurse gave			disability, anxiety, shake	ו	
		of ibuprofen. On 3/14/16			infant syndrome,		
	_	N #2 indicated the			gastrostomy tube, autisti-		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155810	B. W	ING		04/01/	2016
NAME OF I	DDOWNED OD CHIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			1955 S	VERNON ST		
VERNON MANOR CHILDRENS HOME		ENS HOME		WABAS	SH, IN 46992		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		ting in bed, moaning. He			disorder and severe		
		temperature and			cognition impairment.		
	ibuprofen was g	iven.			On the evening of Cunda		
	D : 0.1				On the evening of Sunda	ıy,	
		ital signs record, on			March 13, 2016, the	J	
	1	p.m., Resident B had an			attending nurse identified that Resident B felt warm		
	1	ature of 103.9 degrees			and had a temperature o		
	Fahrenheit (F).				103.9. After administration		
					ibuprofen, she attempted	•	
	A progress note dated 3/14/16 at 11:57				•	1 10	
	a.m., LPN #2 indicated an elevated				contact the attending		
	temperature and "tylenol" given.				physician by phone. The physician did not answer		
					The physician does not		
		on 3/14/16 at 4:16 p.m.,			have voicemail set up an	d	
	LPN #2 indicate	ed an elevated			the nurse was unable to	iu	
	temperature of 1	00 degrees F.			leave a message. She		
					subsequently completed	2	
	A progress note	dated 3/14/16 at 5:03			SBAR (Subject Backgrou		
		LPN #2 notified "Md of			Assessment Request) ar		
	increase temps."	The physician			faxed it to the physician	10	
	responded to mo	onitor the resident at this			(Exhibit A.) The facility		
	time.				received confirmation that	at	
					the fax was received		
	A progress note	dated 3/14/16 at 7:00			(Exhibit B.). Vernon Man	or	
	p.m., RN #1 ind	icated an elevated			received no response.	0.	
	temperature of 1	02.5 F. Ibuprofen was			Todaliou no response.		
	given. RN #1 no	oted the abdomen to be			The next morning, at 9:5	7	
	"slightly firm an	d tender to palpation,			a.m. a Vernon Manor nu		
	resident is expel	ling gas."			notified the physician's		
					nurse that Resident B ha	ıd	
	A note dated 3/1	4/16 at 8:02 p.m., RN #1			elevated temperatures.		
		vated temperature of			Approximately two hours		
		icated the resident			later Vernon Manor		
		ve abdominal tenderness			received an order to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155810	B. W	ING	04/01/2016		2016
NAME OF I	DDOMDED OD SLIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			1955 S	VERNON ST		
VERNON MANOR CHILDRENS HOME			WABAS	SH, IN 46992			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		.:h:4	DATE
	with palpation.				monitor the resident (Exh C and D.) Neither a	IIDIL	
		1 . 12/15/16 . 12.52			discontinuation of an		
		dated 3/15/16 at 12:52				.	
	-	esident was afebrile			existing form of treatmen		
	(temperature not	*			nor a commencement of new form of treatment wa		
		el sounds and discomfort				aS	
	with palpation.				ordered at that time.		
	A progress note dated 3/15/16 at 1:29 p.m., indicated the physician was notified				The principal focus of tag	ı F	
					157 seems to be the	´	
				performance of the staff			
	of the residents vital signs and abdominal tenderness. No specific numbers were				after Resident B was not	ed	
		pecific numbers were			as having a high		
	indicated.				temperature on March 13	3. l	
		1 . 12/15/16 . 2.40			Vernon Manor contends		
		dated 3/15/16 at 2:49			that it used reasonable		
		icated a new order for			efforts to advise and		
		ive the following: "chest			consult with Resident B's	,	
		Blood Count (CBC),			physician concerning the		
		Panel (BMP) and 2 sets			change in Resident B's		
		s done 15 minutes apart."			temperature on March 13	3. l	
		ted the chest x-ray would			Shortly after the increase		
	be done "tonight	."			temperature was noted, a		
					call was placed to the		
		dated 3/15/16 at 5:00			physician. The physiciar	1	
	*	dicated "may have labs			did not answer. The		
	drawn 3/16/16 ii	n the AM per [name of			physician acknowledges		
	physician].				that she does not have		
					voice mail set up. Nursin	g l	
	A progress note	dated 3/16/16 at 1:58			measures were	-	
	a.m., LPN #5 in	dicated the breath sounds			implemented, including		
	had rhonchi [lov	v-pitched] breath sounds.			monitoring of vital signs		
					each shift. As the prefer	red	
	A progress note	dated 3/16/16 at 8:30			method of contacting the		
	a.m., indicated "	CBC, BMP and blood			physician had not worked		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	A. BUILDING <u>00</u>		COMPLETED	
		155810			04/01/2016		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			1	VERNON ST		
VERNON	I MANOR CHILDRE	ENS HOME	<u>_</u>		SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	<u> </u>	DATE	
	_	er hosp lab from left			the nurse followed up wit	n a	
		5 minutes later 2nd set of			fax to the physician		
	blood cultures di	rawn from right hand."			advising of the change. T		
					surveyor's criticism of the		
	A note dated 3/1	6/16 at 12:27 p.m.,			Vernon Manor nurse for r		
	indicated the Dir	ector of Nursing (DON)			doing additional follow-up	is	
	informed the phy	vsician of the chest x-ray			unwarranted, as Vernon		
		y indicated a right			Manor received verification	on	
		e. The physician was			that the fax had been		
	1 ^	he CBC and BMP			received.		
results.							
	resures.				We also note		
	A new order was	s received on 3/16/16 at			inconsistencies in the		
					survey. Page 15 includes		
	_	rder indicated to start			statement from the		
	-	ibiotic] 800mg/160mg, 1			physician that she receive	ed	
	·	for 10 days and			no updates on Resident I		
	_	piotic] 500 mg daily for			condition on March 16. In		
	*	mily was notified of the			fact, the physician's nurs		
	order.				was present in Vernon		
					Manor on that day and		
	A progress note	dated 3/17/16 at 2:06			observed Resident B. In		
	a.m., LPN #5 inc	licated "Dr. [name of			addition, it is noted on pa	ge	
	physician] notifi	ed of culture results."			5 that the DON informed	9- 	
	Review of labora	atory blood culture			the physician of the CBC		
	results, dated 3/1	6/16, indicated a			and BMP results.		
	· ·	lt of Streptococcus A.			and Divir Tobults.		
	1 1	PN #5 indicated she had			In addition, communication	n	
	faxed the report and not actually spoken				with the physician regard		
to the doctor.					•		
				Resident B's temperature	:5		
	A progress note dated 3/17/16 at 7:30				and general status	.	
	1 -				continued on March 15 a		
		ne DON spoke to the			1:29 p.m. (Exhibit E), Ma		
	1 ^ -	the positive blood			15 at 2:49 p.m. (Exhibit I	-),	
	culture, related t	o isolation precautions.			March 15 at 5:00 p.m.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155810	B. WI	NG		04/01/2016	
				CTD FET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	4					
VEDNON		INC LIOME			VERNON ST		
VERNON MANOR CHILDRENS HOME			WABAS	SH, IN 46992			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					(Exhibit G), March 16 at		
	A note on 3/17/1	6 at 8:40 a.m., indicated			12:27 p.m. (Exhibit H),		
		observed between the			March 16 at 3:48 p.m.		
		l, "crawling as per			(Exhibit I), March 17 at 2:	06	
		dent B was observed to			a.m. (Exhibit J), March 17		
					at 5:10 a.m. (Exhibit K),		
		ng abrasions: 4.5 cm x			March 17 at 7:30 a.m.		
	_	ht temple and a 2 cm x 2				ot.	
	_	e. Emesis was on his			(Exhibit L) and March 17	aι	
	clothing and bedding. LPN #3 indicated				9:00 a.m. (Exhibit M).	al .	
	"BrSo [breath sounds] are clear and BoSo				Resident B was evaluated	a	
	[bowel sounds]	active in all four			by the physician on the		
	quadrants".				morning of March 17 and		
	1				subsequently transferred	to	
	Δt 9:00 am the	physician was notified			a hospital.		
		resident's vital signs and					
	•	•			Attached as Exhibit N is a	a	
		e resident. The order			chronology showing		
		d the resident to the local			communications and		
	hospital. Reside	nt B was transported to			significant events involving	na	
	the hospital on 3	/17/16 at 9:15 a.m.			Resident B over the period	•	
					·	u	
	Review of an Ev	ent Report, dated			in question. The events		
		o.m., LPN #5 noted a			identified in 2567 are		
		03.8 degrees F. The			shaded. Exhibit N shows		
	•	•			that there were more		
	•	the event started on			communications between	1	
		o.m. The report indicated			Vernon Manors' nursing		
		ried: Yes Date/Time:			staff, the physician, and t	he	
	3/14/16 at 12:51	AM".			physician's nurse than		
					reflected in the 2567.		
	During an interv	iew on 3/31/16 at 9:20			Several of these additiona	al	
	_	an indicated she was not			communications are set	- '	
		evated temperature of			forth in Exhibit O.		
		eated she was notified of					
					Tog E 224 222242 that		
	-	Monday from her nurse.			Tag F 224 asserts that		
	The physician's	nurse, LPN #6, indicated			Vernon Manor violated		

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	OF CORRECTION OF CORRECTION 155810	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/01/2016
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	she had received a text message from LPN #2 on 3/14/16 at 9:57 a.m., indicating Resident B had a temperature in the 100 range and had vomited his narcotic medication. The physician indicated she was informed on Tuesday (3/15/16) the resident had abdominal tenderness, but with positive bowel sounds. She received no update on Wednesday(3/16/16). She indicated on Thursday (3/17/16), she had received a fax at 2:35 a.m., indicating a positive blood culture. The report only indicated the resident had Gram Positive Cocci (GPC). She indicated she had spoken to the DON prior to her 8:00 a.m. meeting. She indicated the DON was concerned about the blood culture containing streptococcus pyogenes (strep A). The physician indicated she was not aware of the recent culture results. She indicated she immediately contacted her nurse and gave an order for Penicillin 2 million units intravenously every 4 hours with no stop date. She indicated she gave that order around 7:55 a.m., just before her meeting started. During an interview on 3/31/16 at 9:20 a.m., LPN #6 indicated she wrote the order on a sticky note and gave to LPN #3. The note indicated an order for Penicillin 2 million units intravenously every 4 hours with no stop date		regulation 42 CFR 483.13(c), and the same observations used to support F 157 are used to support F 224. We make the same responses to F 224 as to F 157. We furthermore dispute to conclusion on page 11 the "the facility failed to ensure the physician was notified in a timely manned for a resident's increased body temperature. This failure resulted in a delay medical care, hospitalization and death. This is a speculative conclusion without clear clinical sourcing, and is inappropriate to a 2567. Unless there is a documented clinical basi from an authoritative source, this language should be deleted	he nat ser vin
	every + nours with no stop trate	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/01/2016		
VERNO	PROVIDER OR SUPPLIER N MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	During review of the chart, no order for the penicillin was found.					
	The physician indicated she arrived at the facility at 9:00 a.m. on 3/17/16 and went straight to Resident B's room. She indicated he was listless on his bed and had breathing rapid at about 45 breaths per minute. His hands were cyanotic and cold. His heart rate was between 135-145 beats per minute. She indicated she could tell from the doorway that he was acutely ill. She told the staff to send him to the hospital. She indicated the staff was going to call the local fire department for transfer, but she insisted it was an emergency and to call 911. She indicated "there was no sense of urgency from staff." She indicated she had her phone on her 24 hours per day and staff could also call her nurse. She indicated she often received faxes at her home, but would leave early and get home late. She was also not wakened by a fax, but would never sleep through a phone call. During an interview on 3/31/16 at 12:13 p.m., LPN #3 indicated she was told by the DON to "not write the order for the penicillin" because the resident had already been transferred. She indicated she did receive the order from the physician's nurse. She indicated when					

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If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 04/01/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETION DATE	
	was no one in the	es were ordered, there e facility that could draw e facility did not have the a blood culture.					
	p.m., the DON in the physician on indicated the fac supplies to draw time and she was could draw the c indicated she spo because she was herself, may nee antibiotics. She	iew on 3/31/16 at 1:06 indicated she did talk to Thursday. The DON ility did not have the the blood culture at that is the only person who ultures. The DON oke to the physician concerned that she, d prophylactic indicated the physician ed to hear the culture					
	3/14/16 at 1:04 a DON on 3/31/16 LPN #5 faxed th	confirmation dated a.m., provided by the at 2:51 p.m., indicated e elevated temperature at rs after the noted 03.8 F.					
	p.m., LPN #5 inchave a temperatu She indicated she Background Ass Recommendation 12:46 a.m. She	dicated the resident did are over 103.0 degrees F. e created the Situation essment in (SBAR) on 3/14/16 at indicated she faxed the visician, but did not hear					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5PYK11

Facility ID: 000274

If continuation sheet

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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155810	B. W	ING		04/01/	2016
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VERNON ST		
VERNON MANOR CHILDRENS HOME				WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		She indicated she told the					
	charge nurse, but	t could not remember					
	who it was. She	indicated she did not					
	find any addition	nal attempts to contact					
	the physician.						
	She indicated Re	esident B had been					
		evious day and that					
		en sick. She stated she					
		tal signs throughout the					
		t document any of them.					
	· ·	e fax number she sent the					
		ted as the physicians'					
	_	ne. She indicated she					
		the time frame for calling					
	pnysicians or vii	tal sign parameters.					
	Davious of the Su	abject, Objective,					
		Plan (SOAP) note, dated					
		i.m., the physician					
		ve for group A strep.					
		G 2m units IV q4h was					
		as possible. When					
	_	t] was seen this morning,					
	he appeared acut	-					
	tachypneic and ta	achycardic.					
	Review of a curr	ent facility policy, dated					
	9/10/13 and title	d "Notification of					
	Change" provide	ed by the DON on					
		ı.m., indicated the					
	following:						
	"Purpose: Comr	nunicate to the resident,					

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Event ID:

5PYK11 Facility ID: 000274

If continuation sheet Page 11 of 27

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	(X3) DATE SURVEY COMPLETED			
		155810	B. WING		04/01/2016		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
	•	interested family change in condition					
	physical mental (i.e. deterioration psychosocial sta	ange in the residents or psychosocial status in health, mental or tus in either conditions or clinical					
	A need to alter to	reatment					
	5. Follow up r						
	3/31/16 at 12:00 3/31/16 when the provide timely c abnormal vital si The Immediate J 4/1/16 when the plan of action to	eopardy was identified on p.m. The IJ began on e facility failed to communication related gns to the physician. The interpretation included the second secon					

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Event ID:

5PYK11

Facility ID: 000274

If continuation sheet

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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/01 /	ETED	
	PROVIDER OR SUPPLIER			1955 S \	DDRESS, CITY, STATE, ZIP CODE VERNON ST H, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	notified of any s resident's physic psychosocial sta 2. An SBAR wi completed which information comphysician includ status, functional status, GI/abdom 3. All attempts to will be document record. 4. The physician telephone using communication of changes of conditional the physician via messaging. In the event the first the physician in Executive Direct Nursing/designe. During an interval.m., the Adminition of changes of conditional contacting the platelephone. She is had been posted each person had	tus. Il be thoroughly In will include the detailed In will signs, mental I status, respiratory I status, labs, etc. I o notify the physician I ted in the medical In will be contacted via I the facility phone. No I regarding orders or I tion will take place with I fax, email or text I the tor and Director of I with be contacted." I will be contacted via I will be contacted via					

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Event ID:

5PYK11

Facility ID: 000274

If continuation sheet

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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			l í		NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810				JILDING	00	COMPL	
		155810	B. W	ING		04/01/	2016
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1955 S	VERNON ST		
	I MANOR CHILDRE			<u> </u>	SH, IN 46992		
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	She indicated the						
	inservicing the n	ursing staff shortly after					
	noon on 3/31/16.	She indicated the DON					
	provided each nu	irse with a policy to					
	notify the physic	ian of any change. Each					
		to date and sign the					
	form. The nursi	_					
		e facility policy for					
	"Notification of	3 1 3					
	Notification of	Change.					
	Nursing staff on	duty were interviewed					
	_	firm each understood the					
		olicy. Staff interviewed					
		•					
		1, LPN # 10, RN # 9,					
	•	, and RN #8. Each staff					
	•	e of the inservice and					
	changes made to	machine compliance.					
	This Federal tag	relates to Complaint					
	IN00196359.	P					
	3.1-5(a)(2)						
	$\int J \cdot 1 - \mathcal{J}(\mathbf{a})(2)$						
E 0004	400 40/->						
F 0224 SS=J	483.13(c) PROHIBIT						
SS=J Bldg. 00		/NEGLECT/MISAPPROP					
ычу. 00	RIATN						
	-	evelop and implement					
		d procedures that prohibit					
	mistreatment, neg	lect, and abuse of appropriation of resident					
	residents and mis	appropriation of resident					

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Event ID:

5PYK11 Facility ID: 000274

If continuation sheet Page 14 of 27

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155810	B. WI	NG		04/01/	2016
				CTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
VEDNON		TNIC LIONAT			VERNON ST		
VERNO	VERNON MANOR CHILDRENS HOME			WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	property.						
	Based on intervi	ew and record review,	F 02	224	F224J Prohibit		04/18/2016
	the facility failed	d to ensure the physician			Mistreatment/Neglect	_	
	was notified in a	timely manner of a			Corrective action for affected	d	
		sed body temperature.			residents: Resident B		
		lted in a delay in medical			discharged Identification of others at risk: Interviewable		
		•			residents were interviewed ar		
		tion and death (Resident			non-interviewable residents w	-	
	B).				assessed for any signs of abu		
					or neglect. No concerns were		
	The immediate j	eopardy began on			identified. Measures to ensur	re	
	3/13/16 when th	e facility failed to notify			this deficit practice does not		
	the physician of	an elevated temperature			recur: License nurses were		
	_ ~ ~	Fahrenheit (F). The			educated to the Abuse & Negl	ect	
	_	tor, Director of Nursing			Policy and Procedure.		
		_			Monitoring of corrective		
	_	rector were notified of			action: Residents with signific	ant	
		eopardy on 3/31/16 at			changes in condition will be	_	
	12:00 p.m. The	Immediate Jeopardy was			reviewed for signs of abuse on neglect 5 times weekly for 6	ır	
	removed 4/1/16	when the facility			months, then 2 times weekly	for	
	developed and in	mplemented a systematic			6 months. Results of this	101	
	plan of correction	•			monitoring will be reported		
					through the QA Committee for	-	
	Findings include				further recommendations. Pla	an	
	i manigs include	.			of Compliance is effective:		
					April 18, 2016 Vernon Manor		
	1	eview on 3/29/16 at 9:55			requests changes in two		
	a.m., the clinical	record indicated			deficiencies alleged in the 256		
	Resident B was	admitted to the facility			for the survey completed April 2016: we request a reduction		
	on 10/27/12. Di	agnoses included, but			the scope and severity of findi		
	were not limited to, spastic quadriplegic				F157 and the removal of findir		
	cerebral palsy, profound intellectual				F224 Mistreatment, Neglected	•	
					Misappropriation. All findings		
	disability, anxiety, shaken infant				associated with these tags rel		
	syndrome and gasterostomy tube. The				to the same individual, Reside	ent	
		Set (MDS) quarterly			B. Please see attached IDR		
	assessment dated	d 1/7/16, indicated			request		
	Resident B was	unable to complete the			Resident B was admitted		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155810	B. W	ING		04/01/2	2016
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
VEDNION		TNC HOME			VERNON ST		
VERNO	N MANOR CHILDRE	ENS HOME		WADAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Brief Interview	Mental Status (BIMS).			Vernon Manor on		
	Resident B was severely cognitively impaired. During review of a progress note dated				10/27/2012. His diagnose	es	
					included spastic		
					quadriplegic cerebral pals	21/	
					profound intellectual	,	
					l '		
		o.m., RN #1 noted a			disability, anxiety, shaker	·	
	fever. The note indicated the nurse gave				infant syndrome,		
	600 milligrams	of ibuprofen. On 3/14/16			gastrostomy tube, autistic	7	
	at 6:00 a.m., LP	N #2 indicated the			disorder and severe		
	resident was rest	ting in bed, moaning. He			cognition impairment.		
	had an elevated	temperature and					
	ibuprofen was given.				On the evening of Sunda	y,	
	Toupforch was g.	1 () ()			March 13, 2016, the		
	D : C/1	9 1 · 1			attending nurse identified		
		tal signs record, on			that Resident B felt warm		
	^	o.m., Resident B had an			and had a temperature of		
	elevated tempera	ature of 103.9 degrees			103.9. After administrating		
	Fahrenheit (F).					- 1	
					ibuprofen, she attempted	lo	
	A progress note	dated 3/14/16 at 11:57			contact the attending		
		dicated an elevated			physician by phone. The		
	temperature and				physician did not answer.	•	
		tylenor given.			The physician does not		
	.				have voicemail set up an	d	
		on 3/14/16 at 4:16 p.m.,			the nurse was unable to		
	LPN #2 indicate				leave a message. She		
	temperature of 1	00 degrees F.			subsequently completed	a l	
					SBAR (Subject Backgrou		
	A progress note	dated 3/14/16 at 5:03			Assessment Request) an		
		LPN #2 notified "Md of			faxed it to the physician		
	increase temps."						
	•	onitor the resident at this			(Exhibit A.) The facility	.	
	_	onnor the resident at this			received confirmation tha	IT	
	time.				the fax was received		
					(Exhibit B.). Vernon Mand	or	
	A progress note	dated 3/14/16 at 7:00			received no response.		
	p.m., RN #1 ind	icated an elevated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ED
		155810	B. W	ING		04/01/20	016
MANGEOGR	ADOLUDED OF GUIDE YES	`	1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		1955 S	VERNON ST		
	I MANOR CHILDRE		_		SH, IN 46992	,	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1.	(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE C	COMPLETION DATE
TAG				TAG	·	7	DATE
	temperature of 102.5 F. Ibuprofen was given. RN #1 noted the abdomen to be				The next morning, at 9:57 a.m. a Vernon Manor nur		
						SE	
	"slightly firm and tender to palpation, resident is expelling gas."				notified the physician's nurse that Resident B ha	۸	
						u	
		1/4 6			elevated temperatures.		
		4/16 at 8:02 p.m., RN #1			Approximately two hours later Vernon Manor		
		vated temperature of			received an order to		
	· · · · · · · · · · · · · · · · · · ·	icated the resident			monitor the resident (Exh	ibit	
		e abdominal tenderness			C and D.) Neither a	libit	
	with palpation.				discontinuation of an		
					existing form of treatmen	.	
		dated 3/15/16 at 12:52			nor a commencement of		
	p.m., indicated r	esident was afebrile			new form of treatment wa		
	(temperature not	t elevated) with				15	
	hypoactive bowe	el sounds and discomfort			ordered at that time.		
	with palpation.				The principal feets of tea		
					The principal focus of tag 157 seems to be the		
	A progress note	dated 3/15/16 at 1:29			performance of the staff		
	p.m., indicated t	he physician was notified			after Resident B was note	od	
	of the residents	vital signs and abdominal			as having a high	s u	
	tenderness. No s	pecific numbers were			temperature on March 13	,	
	indicated.				Vernon Manor contends	,.	
					that it used reasonable		
	A progress note	dated 3/15/16 at 2:49			efforts to advise and		
	p.m., RN #4 ind	icated a new order for			consult with Resident B's		
		ive the following: "chest			physician concerning the		
		Blood Count (CBC),			change in Resident B's		
	Basic Metabolic Panel (BMP) and 2 sets of blood cultures done 15 minutes apart." The order indicated the chest x-ray would be done "tonight."				temperature on March 13		
					Shortly after the increase		
					temperature was noted, a		
					call was placed to the	²	
					physician. The physician		
	A progress note	dated 3/15/16 at 5:00			did not answer. The	'	
	p.m., LPN #3 in	dicated "may have labs			physician acknowledges		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		155810	B. W	ING		04/01/	/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			VERNON ST			
VERNON	MANOR CHILDRE	ENS HOME			6H, IN 46992			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	drawn 3/16/16 ii	n the AM per [name of			that she does not have			
	physician].				voice mail set up. Nursin	g		
					measures were			
	A progress note	dated 3/16/16 at 1:58			implemented, including			
	a.m., LPN #5 inc	dicated the breath sounds			monitoring of vital signs			
	had rhonchi [lov	v-pitched] breath sounds.			each shift. As the prefer	red		
	nad monem [low-phened] breath sounds.				method of contacting the			
	A progress note	dated 3/16/16 at 8:30			physician had not worked	d,		
		CBC, BMP and blood			the nurse followed up wit	h a		
		per hosp lab from left			fax to the physician			
		5 minutes later 2nd set of			advising of the change.	he		
		rawn from right hand."			surveyor's criticism of the)		
	biood cuitures d	rawn from fight hand.			Vernon Manor nurse for	not		
		(116 + 12 27			doing additional follow-up	o is		
		6/16 at 12:27 p.m.,			unwarranted, as Vernon			
		rector of Nursing (DON)			Manor received verification	on		
		ysician of the chest x-ray			that the fax had been	J.,		
		ay indicated a right			received.			
		te. The physician was			1.000.1.00.			
	also notified of t	he CBC and BMP			We also note			
	results.				inconsistencies in the			
					survey. Page 15 includes	,		
	A new order was	s received on 3/16/16 at			statement from the	,		
	3:48 p.m. The o	order indicated to start				od		
	_	ibiotic] 800mg/160mg, 1			physician that she receiv			
	-	y for 10 days and			no updates on Resident			
	·	piotic 500 mg daily for			condition on March 16. Ir			
	_	2 2			fact, the physician's nurs	е		
	10 days. The family was notified of the				was present in Vernon			
	order.				Manor on that day and			
	A				observed Resident B. In			
	A progress note dated 3/17/16 at 2:06				addition, it is noted on pa	ige		
	a.m., LPN #5 indicated "Dr. [name of				5 that the DON informed			
	physician] notified of culture results."				the physician of the CBC			
		atory blood culture			and BMP results.			
	results, dated 3/1	16/16, indicated a						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		155810	B. W	ING		04/01/2	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			VERNON ST		
VERNON	N MANOR CHILDRE	ENS HOME			SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ГЕ	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	preliminary result of Streptococcus A.				In addition, communication		
	Interview with LPN #5 indicated she had				with the physician regard	- 1	
	faxed the report and not actually spoken to the doctor.				Resident B's temperature	:S	
					and general status		
					continued on March 15 at		
	A progress note	dated 3/17/16 at 7:30			1:29 p.m. (Exhibit E), Mai		
	a.m., indicated to	he DON spoke to the			15 at 2:49 p.m. (Exhibit F	-),	
	physician about	the positive blood			March 15 at 5:00 p.m.		
	culture, related t	o isolation precautions.			(Exhibit G), March 16 at		
					12:27 p.m. (Exhibit H),		
	A note on 3/17/1	6 at 8:40 a.m., indicated			March 16 at 3:48 p.m.		
		observed between the			(Exhibit I), March 17 at 2:	06	
		d, "crawling as per			a.m. (Exhibit J), March 17	7	
		dent B was observed to			at 5:10 a.m. (Exhibit K),		
		ng abrasions: 4.5 cm x			March 17 at 7:30 a.m.		
		ht temple and a 2 cm x 2			(Exhibit L) and March 17	at	
	_	e. Emesis was on his			9:00 a.m. (Exhibit M).		
	_	lding. LPN #3 indicated			Resident B was evaluated	d	
	_	•			by the physician on the		
	-	ounds] are clear and BoSo			morning of March 17 and		
		active in all four			subsequently transferred	to	
	quadrants".				a hospital.		
	At 9:00 am the	e physician was notified					
		resident's vital signs and			Attached as Exhibit N is a	a	
	•	ne resident. The order			chronology showing		
					communications and		
	_	id the resident to the local			significant events involving	-	
	-	ent B was transported to			Resident B over the perio	od	
	the hospital on 3	/17/16 at 9:15 a.m.			in question. The events		
					identified in 2567 are		
	Review of an Event Report, dated				shaded. Exhibit N shows		
	3/13/16 at 6:45 p.m., LPN #5 noted a				that there were more		
	temperature of 103.8 degrees F. The				communications between	1	
	^	the event started on			Vernon Manors' nursing		
	3/13/16 at 6:03 p	o.m. The report indicated			staff, the physician, and t	he	

NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME MAD ID SIMMARY STATIMENT OF DEPRETACIES PREFEX PROPERTY MIST BE PRECEDED BY FULL REGULATORY OR LEC DENTIFYING INFORMATION) "Physician Notified: Yes Date/Time: 3/14/16 at 12-51 AM". During an interview on 3/31/16 at 9-20 a.m., the physician indicated she was not notified of an elevated temperature of 103.9. She indicated she was notified of a temperature on Monday from her nurse. The physician's nurse, LPN #6, indicated she had received a text mesage from LPN #2 on 3/14/16 at 9-57 am., indicating Resident B had a temperature in the 100 range and had vomited his narcotic medication. The physician indicated she was informed on Tuesday (3/15/16) the resident had faddominal tenderness, but with positive blood culture. The report only indicated the resident had Gram Positive Cocci (GPC). She indicated she had spoken to the DON prior to her 8:00 a.m. meeting. She indicated she was not indicated she was not more of the recent culture results. She indicated she immediately contacted her nurse and gave an order for Penicillin 2 million units intravenously every 4 hours with no	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	00	(X3) DATE S COMPL		
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PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810			ILDING	NSTRUCTION 00	(X3) DATE COMPL 04/01/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	order around 7:5 meeting started.	5 a.m., just before her						
	a.m., LPN #6 incorder on a sticky #3. The note incorder Penicillin 2 milli every 4 hours wi	•						
	During review of the chart, no order for the penicillin was found.							
	facility at 9:00 a straight to Reside indicated he was had breathing raper minute. His cold. His heart re 135-145 beats per she could tell frow was acutely ill. him to the hospit staff was going the department for the was an emergency indicated "therefrom staff." She phone on her 24 could also call her she often received would leave early	dicated she arrived at the am. on 3/17/16 and went ent B's room. She listless on his bed and pid at about 45 breaths hands were cyanotic and rate was between er minute. She indicated om the doorway that he she told the staff to send rate. She indicated the o call the local fire ransfer, but she insisted it bey and to call 911. She was no sense of urgency indicated she had her hours per day and staff er nurse. She indicated ad faxes at her home, but y and get home late. She sened by a fax, but would						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5PYK11

Facility ID: 000274

If continuation sheet

Page 21 of 27

PRINTED: 04/21/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			î ´		NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155810				JILDING	00	COMPL	
		155810	B. W	ING		04/01/	2016
NAME OF P	ROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					VERNON ST		
VERNON	I MANOR CHILDRE	ENS HOME		WABAS	5H, IN 46992		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	,			TAG	DEFICIENCY)		DATE
	never sleep throu	igh a phone call.					
	_	iew on 3/31/16 at 12:13					
	p.m., LPN #3 inc	dicated she was told by					
	the DON to "not	write the order for the					
	penicillin" becau	se the resident had					
	already been tran	nsferred. She indicated					
	she did receive the	he order from the					
	physician's nurse	e. She indicated when					
	the blood culture	es were ordered, there					
		e facility that could draw					
	the blood and the	e facility did not have the					
	supplies to draw						
	During an interv	iew on 3/31/16 at 1:06					
	_	ndicated she did talk to					
	•	Thursday. The DON					
		ility did not have the					
		the blood culture at that					
		s the only person who					
		ultures. The DON					
	_	oke to the physician					
		concerned that she,					
	herself, may nee	1 1 2					
		indicated the physician					
	_	ed to hear the culture					
	grew strep A.						
		confirmation dated					
	3/14/16 at 1:04 a.m., provided by the						
	DON on 3/31/16	at 2:51 p.m., indicated					
	LPN #5 faxed the elevated temperature at						
	1:04 a.m. 7 hours after the noted						
	temperature of 1	03.8 F.					
	_						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL				
		155810	B. W	ING		04/01/	2016		
NAME OF I	PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST						
VERNO	N MANOR CHILDRE	ENS HOME		WABAS	H, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	p.m., LPN #5 inchave a temperatus She indicated she Background Ass Recommendation 12:46 a.m. She substituted SBAR to the physician shows the physician. She indicated Recoughing the precedent of the physician shows the indicated the report to was list home fax machine was unaware of physicians' or virus Review of the States Assessment and 3/17/16 at 8:55 at indicated "positipe PCN [penicillin] ordered as soon and solve the substitute of the	in (SBAR) on 3/14/16 at indicated she faxed the visician, but did not hear She indicated she told the trould not remember indicated she did not hal attempts to contact sident B had been evious day and that en sick. She stated she tal signs throughout the troughout the transport document any of them. It is a sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she the time frame for calling tal sign parameters. The indicated she tall the indicated she time frame for calling tal sign parameters. The indicated she told the indicated she tall the indicated she time frame for calling tall sign parameters.							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		155810	B. W.	ING		04/01/	2016
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
VERNON	I MANOR CHILDRE	ENS HOME			VERNON ST H, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	COMPLETION DATE
	tachypneic and t						
	Review of a curr 8/8/13 and titled AND MISAPPR PROPERTY" pr 3/29/16 at 8:50 a following: "Purpose: Preve misappropriation Procedure: 1. The facility with mental or physic involuntary section involuntary section Training: 3. Staff membrassess E. Neglect, the and services necharm, mental anguing Protection: 1. All residents harm. Review of anoth 9/10/13 and title Change" provide 3/29/16 at 8:50 a following:	rent facility policy, dated "ABUSE, NEGLECT, OPRIATION OF ovided by the DON on i.m., indicated the Int abuse, neglect and in of property. It prohibit neglect, all abuse, including usion and the in of property of residents. It will identity and It failure to provide goods the essary to avoid physical guish, or mental illness. It will be protected from It facility policy, dated the d'Notification of the doty the DON on i.m., indicated the In municate to the resident,					
	representative or	interested family					

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/01/2016			
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	member when a occurs. Notification occurs. An accident	change in condition urs when:					
	physical mental (i.e. deterioration psychosocial sta	ange in the residents or psychosocial status in health, mental or tus in either conditions or clinical					
	A need to alter treatment						
	5. Follow up 1						
	3/31/16 at 12:00 3/31/16 when the provide timely c abnormal vital st The Immediate J 4/1/16 when the plan of action to The corrective at following:	eopardy was identified on p.m. The IJ began on e facility failed to communication related igns to the physician. Ideopardy was removed on facility implemented a correct the deficiency ction included the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	ì í	ILDING	NSTRUCTION 00	(X3) DATE COMPL 04/01 /	ETED
NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	information comphysician includ status, functiona status, GI/abdom 3. All attempts to will be document record. 4. The physician telephone using communication of changes of condition the physician via messaging. In the event the record the physician in Executive Direct Nursing/designe During an interval. The Administration of classification of classification of classification of classification of classification of classification of classification. She is have been posted sign the form incomplete the change. She started inservicing	It be thoroughly a will include the detailed amunicated to the ing vital signs, mental a status, respiratory annal status, labs, etc. so notify the physician ted in the medical at will be contacted via the facility phone. No regarding orders or attion will take place with a fax, email or text a timely manner, the tor and Director of the with be contacted." iew on 4/1/16 at 10:12 attractor indicated the ed all nursing staff on					

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
155810		B. WING		04/01/2016			
NAME OF P	PROVIDER OR SUPPLIER	3	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
WAINE OF T	ROVIDER OR SOLITEIE		1955 S VERNON ST				
VERNON	I MANOR CHILDRI	ENS HOME	WABASH, IN 46992				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY) DATE			
		indicated the DON provided each nurse					
		notify the physician of					
		ch staff person was to					
	date and sign the form. The nursing staff						
	-	ed with the facility policy					
	for "Notification	of Change."					
	Nursing staff on duty were interviewed						
	on 4/1/16 to confirm each understood the						
	changes in the policy. Staff interviewed						
	included LPN# 11, LPN # 10, RN # 9,						
	RN # 4, LPN # 7, and RN #8. Each staff						
	person was aware of the inservice and						
	changes made to machine compliance.						
	changes made to machine comphance.						
	This Federal tag relates to Complaint						
	IN00196359.						
	11100170337.						
	3.1-28(a)						
	3.1 - 20(a)						

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